

CLINICAL RECORD

AUTOPSY PROTOCOL A63-272 (JJH:cc)

DATE AND HOUR DIED A. M. P. M.

22 November 1963 1300 (CST)

PROSECUTOR (497831)  
CDR J. J. HEDGES, MC, USN

CLINICAL DIAGNOSES (Individually operational)

DATE AND HOUR AUTOPSY PERFORMED

22 November 1963 2000 (EST)

ASSISTANT (439878)

CDR "J" THORNTON BOSWELL, MC, USN  
LCOL PIERRE A. VENCK, MC, USA (04 043 322)

A. M.

CHECK ONE

FULL AUTOPSY

HEAD ONLY

THORAX ONLY

Et. - 72½ inches  
Wt. - 170 pounds  
Eyes - blue  
Hair - reddish brown

PATHOLOGICAL DIAGNOSES

CAUSE OF DEATH: Gunshot wound, head.

APPROVED SIGNATURE

J. J. HEDGES, CDR, MC, USN

MILITARY ORGANIZATION (Last Name)

PRESIDENT, UNITED STATES

AGE

46

SEX

Male

RACE

Caucasian

IDENTIFICATION NO.

REGISTER NO.

AUTOPSY NO.

A63-272

REGISTER NO.

WARD NO.

KENNEDY, JOHN F.  
NAVAL MEDICAL SCHOOL

AUTOPSY PROTOCOL  
STANCO FORM 503

JH8 JET

## CLINICAL SUMMARY:

According to available information the deceased, President John F. Kennedy, was riding in an open car in a motorcade during an official visit to Dallas, Texas on 22 November 1963. The President was sitting in the right rear seat with Mrs. Kennedy seated on the same seat to his left. Sitting directly in front of the President was Governor John B. Connally of Texas and directly in front of Mrs. Kennedy was Mrs. Connally. The vehicle was moving at a slow rate of speed down an incline into an underpass that leads to the freeway route to the Dallas Trade Mart. The President was to deliver an

fell forward bleeding from the head. (On same gunfire.) According to newspaper reporter Bob Jackson, a Dallas "Times Herald" Photos the shot and saw a rifle barrel disappear in nearby Texas School Book Depository Building.

He looked out window on an upper floor.

Shortly following the wounding of the two men the car was driven to Parkland Hospital in Dallas. In the emergency room of that hospital the President was attended by Dr. Malcolm Perry. Telephone communication with Dr. Perry on November 23, 1963 develops the following information relative to the observations made by Dr. Perry and procedures performed there prior to death.

Dr. Perry noted the massive wound of the head and a second much smaller wound of the low anterior neck in approximately the midline. A tracheostomy was performed by extending the latter wound. At this point bloody air was noted bubbling from the wound and an injury to the right lateral wall of the trachea was observed. Incisions were made in the upper anterior chest wall bilaterally to combat possible subcutaneous emphysema. Intravenous infusions of blood and saline were begun and oxygen was administered. Despite these measures cardiac arrest occurred and closed chest cardiac massage failed to re-establish cardiac action. The President was pronounced dead approximately thirty to forty minutes after receiving his wounds.

The remains were transported via the Presidential plane to Washington, D.C. and subsequently to the Naval Medical School, National Naval Medical Center, Bethesda, Maryland for postmortem examination.

## GENERAL DESCRIPTION OF BODY:

The body is that of a muscular, well-developed and well nourished adult Caucasian male measuring 72½ inches and weighing approximately 170 pounds. There is beginning rigor mortis, minimal dependent livor mortis of the dorsum, and early rigor mortis. The hair is reddish brown and abundant, the eyes are blue, the right pupil measuring 8 mm. in diameter, the left 4 mm. There is edema and ecchymosis of the inner canthus region of the left eyelid measuring approximately 1.5 cm. in greatest diameter. There is edema and ecchymosis diffusely over the right supra-orbital ridge with abnormal mobility of the underlying bone. (The remainder of the scalp will be described with the skull.)

There is clotted blood on the external ears but otherwise the ears, parotid, and mouth are essentially unremarkable. The teeth are in excellent repair and there is some pallor of the oral mucous membranes.

7/25  
Sited on the upper right side of the scapula there is a 7 x 4 cm. wound. This wound is measured to 14 cm. from the tip of the right and 14 cm. below the tip of the right mastoid process.

posterior  
motor oval  
tendon process

proximately the level of the third and  
verse wound with widely gaping irregular  
wounds will be further described below.)

7/25  
1 in the low ante-  
ro-lateral aspect of the right thigh at the  
thigh

nipple line are bilateral 2 cm. long recent transverse subcutaneous tissue. The one on the left is 1 cm. cephalad to the nipple and the one on the right 3 cm. cephalad to the nipple. There is no hemorrhage or ecchymosis associated with these wounds. A similar clean wound measuring 2 cm. in length is situated on the antero-lateral aspect of the left mid arm. Situated on the antero-lateral aspect of each ankle is a recent 2 cm. transverse incision into the subcutaneous tissue.

There is an old well healed 8 cm. McBurney abdominal incision. Over the lumbar spine in the midline is an old, well healed 15 cm. scar. Situated on the upper antero-lateral aspect of the right thigh is an old, well healed 8 cm. scar.

#### MISSILE WOUNDS:

1. There is a large irregular defect of the scalp and skull on the right involving chiefly the parietal bone but extending somewhat into the temporal and occipital regions. In this region there is an actual absence of scalp and bone producing a defect which measures approximately 13 cm. in greatest diameter.

From the irregular margins of the above scalp defect tears extend in stellate fashion into the more or less intact scalp as follows:

- a. From the right inferior temporo-parietal margin anterior to the right ear to a point slightly above the tragus.
- b. From the anterior parietal margin anteriorly on the forehead to approximately 4 cm. above the right orbital ridge.
- c. From the left margin of the main defect across the midline antero-laterally for a distance of approximately 8 cm.
- d. From the same starting point as c. 10 cm. postero-laterally.

Situated in the posterior scalp approximately 2.5 cm. laterally to the right and slightly above the external occipital protuberance is a lacerated wound measuring 15 x 6 mm. In the underlying bone is a corresponding wound through the skull which exhibits beveling of the margins of the bone when viewed from the inner aspect of the skull.

Clearly visible in the above described large skull defect and exuding from it is lacerated brain tissue which on close inspection proves to represent the major portion of the right cerebral hemisphere. At this point it is noted that the falk cerebri is extensively lacerated with disruption of the superior sagittal sinus.

Upon reflecting the scalp multiple complete fracture lines are seen to radiate from both the large defect at the vertex and the smaller wound at the occiput. These vary greatly in length and direction, the longest measuring approximately 19 cm. These result in the production of numerous fragments which vary in size from a few millimeters to 10 cm. in greatest diameter.

The complexity of these fractures and the fragments thus produced tax satisfactory verbal description and are better appreciated in photographs and roentgenograms which are prepared.

The brain is removed and preserved for further study following formalin fixation.

Received as separate specimens from Dallas, Texas are three fragments of skull bone which in aggregate roughly approximate the dimensions of the large defect described above. At one angle of the largest of these fragments is a portion of the perimeter of a roughly circular wound presumably of exit which exhibits beveling of the outer aspect of the bone and is estimated to measure approximately 2.5 to 3.0 cm. in diameter. Roentgenograms of this fragment reveal minute particles of metal in the bone at this margin. Roentgenograms of the skull reveal multiple minute metallic fragments along a line corresponding with a line joining the above described small occipital wound and the right supra-orbital ridge. From the surface of the disrupted right cerebral cortex two small irregularly shaped fragments of metal are recovered. These measure 7 x 2 mm. and 3 x 1 mm. These are placed in the custody of Agents Francis X. O'Neill, Jr. and James W. Sibert, of the Federal Bureau of Investigation, who executed a receipt therefor (attached).

2. The second wound presumably of entry is that described above in the upper right posterior thorax. Beneath the skin there is ecchymosis of subcutaneous tissue and musculature. The muscle path through the fascia and musculature cannot be easily probed. The wound presumably of exit was that described by Dr. Malcolm Perry of Dallas in the low anterior cervical region. When observed by Dr. Perry the wound measured "a few millimeters in diameter", however it was extended as a tracheostomy incision and thus its character is distorted at the time of autopsy. However, there is considerable ecchymosis of the strap muscles of the right side of the neck and of the fascia about the trachea adjacent to the line of the tracheostomy wound. The third point of reference in connecting

those two wounds is in the apex (supra-clavicular portion) of the right pleural cavity. In this region there is contusion of the parietal pleura and of the extreme apical portion of the right upper lobe of the lung. In both instances the diameter of contusion and ecchymosis at the point of maximal involvement measures 5 cm. Both the visceral and parietal pleura are intact overlying these areas of trauma.

## INCISIONS:

The scalp wounds are extended in the coronal plane to examine the cranial content and the customary (Y) shaped incision is used to examine the body cavities.

## THORACIC CAVITY:

The bony cage is unremarkable. The thoracic organs are in their normal positions and relationships and there is no increase in free pleural fluid. The above described area of contusion in the apical portion of the right pleural cavity is noted.

## LUNGS:

The lungs are of essentially similar appearance the right weighing 320 Gm., the left 290 Gm. The lungs are well aerated with smooth glistening pleural surfaces and gray-pink color. A 5 cm. diameter area of purplish red discoloration and increased firmness to palpation is situated in the apical portion of the right upper lobe. This corresponds to the similar area described in the overlying parietal pleura. Incision in this region reveals recent hemorrhage into pulmonary parenchyma.

## HEART:

The pericardial cavity is smooth walled and contains approximately 10 cc. of straw-colored fluid. The heart is of essentially normal external contour and weighs 350 Gm. The pulmonary artery is opened in situ and no abnormalities are noted. The cardiac chambers contain moderate amounts of postmortem clotted blood. There are no gross abnormalities of the leaflets of any of the cardiac valves. The following are the circumferences of the cardiac valves: aortic 7.5 cm., pulmonic 7 cm., tricuspid 12 cm., mitral 11 cm. The myocardium is firm and reddish brown. The left ventricular myocardium averages 1.2 cm. in thickness, the right ventricular myocardium 0.4 cm. The coronary arteries are dissected and are of normal distribution and smooth walled, and elastic throughout.

## ABDOMINAL CAVITY:

The abdominal organs are in their normal positions and relationships and there is no increase in free peritoneal fluid. The vermiform appendix is surgically absent and there are a few adhesions joining the region of the cecum to the ventral abdominal wall at the above described old abdominal incisional scar.

## SKELETAL SYSTEM:

Aside from the above described skull wounds there are no significant gross skeletal abnormalities.

## PHOTOGRAPHY:

Black and white and color photographs depicting significant findings are exposed but not developed. These photographs were placed in the custody of Agent Roy H. Kellerman of the U. S. Secret Service, who executed a receipt therefore (attached).

## ROENTGENOGRAMS:

Roentgenograms are made of the entire body and wereately submitted three fragments of skull bone. These are devotedly placed in the custody of Agent Roy H. Kellerman of the U. S. Secret Service, who executed a receipt therefor (attached).

## SUMMARY:

Based on the above observations it is our opinion that the deceased died as a result of two perforating gunshot wounds inflicted by high velocity projectiles fired by a person or persons unknown. The projectiles were fired from a point behind and somewhat above the level of the deceased. The observations and available information do not permit a satisfactory estimate as to the sequence of the two wounds.

The fatal missile entered the skull above and to the right of the external occipital protuberance. A portion of the projectile traversed the cranial cavity in a posterior-anterior direction (see lateral skull roentgenograms) depositing minute particles along its path. A portion of the projectile made its exit through the parietal bone on the right carrying with it portions of cerebrum, skull and scalp. The two wounds of the skull combined with the force of the missile produced extensive fragmentation of the skull, laceration of the superior sagittal sinus, and of the right cerebral hemisphere.

The other missile entered the right superior posterior thorax above the scapula and traversed the soft tissues of the supra-scapular and the supra-clavicular portions of the base of the right side of the neck. This missile produced contusions of the right apical parietal pleura and of the apical portion of the right upper lobe of the lung. The missile comressed the strap muscles of the right side of the neck, damaged the trachea and made its exit through the anterior surface of the neck. As far as can be ascertained this missile struck no bony structures in its path through the body.

In addition, it is our opinion that the wound of the skull produced such extensive damage to the brain as to preclude the possibility of the deceased surviving this injury.

A supplementary report will be submitted following more detailed examination of the brain and of microscopic sections. However, it is not anticipated that these examinations will materially alter the findings.

J. J. Humes  
J. J. HUMES  
CDR, MC, USN (497831)

J. Thornton Boswell  
J. THORNTON BOSWELL  
CDR, MC, USN (489878)

Pierre A. Finch  
PIERRE A. FINCH  
LT COL, MC, USA  
(04-043-322)

J. H. S.  
J. H. S.

## CLINICAL RECORD

## AUTHORIZATION FOR POST-MORTEM EXAMINATION

In the event authorization for post-mortem examination is obtained by letter, telegram, or mechanically recorded telephone call, paragraphs 1 and 2 shall be completed by hospital authorities and the letter, telegram, or memorandum confirming telephone call of authorization attached to this form for permanent file.

## NAME AND LOCATION OF HOSPITAL

1. U.S. Naval Hospital, Bethesda

November 1963

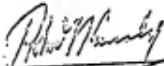
2. You are hereby authorized to perform the post-mortem examination on the remains of

John F. Kennedy

(Name of deceased)

Authority is also granted for the preservation and storage of any and all tissues which may be removed. This authority shall be limited only by the conditions expressly stated below:

Signature  
of witness



Signature (Mrs) John F. Kennedy  
(Person authorized to consent)

Address

Address White House

Washington, D.C.

Authority  
to consent Wife

The performance of the autopsy specified above is approved.

Signature R.O. CANADA CAPT NC USN

Title Commanding Officer

Date 22 November 1963

PATIENT'S IDENTIFICATION (Type, typed or written entries after Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.
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AUTHORIZATION FOR POST-MORTEM  
Standard Form 232